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Citation for published version:

Murray, AL, Crawford, K, McKenzie, K & Murray, G 2011, 'How to develop patient trust in anorexia treatment', *Nursing Times*, vol. 107, no. 3, pp. 24-26.
<<http://www.nursingtimes.net/Journals/2013/01/18/s/p/m/250111How-to--develop--patient-trust-in-anorexia-treatment.pdf>>

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Publisher's PDF, also known as Version of record

Published In:

Nursing Times

Publisher Rights Statement:

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A positive nurse-patient relationship is vital in anorexia recovery but can be difficult to form for many reasons

How to develop patient trust in anorexia treatment

In this article...

- › The characteristics of anorexia nervosa
- › How the disorder affects patients' thought processes
- › Why nurses may have negative attitudes towards patients with the disorder

Authors Aja Louise Murray is a student in the psychology department, University of Edinburgh; Kate Crawford is community psychiatric nurse; Karen McKenzie is consultant clinical psychologist; George Murray is consultant clinical psychologist; all at the Andrew Lang Unit, child and adolescent mental health services, NHS Borders, Selkirk, Scotland.

Abstract Murray AL et al (2011) How to develop patient trust in anorexia treatment. *Nursing Times*; 107: 3, 24-26.

Anorexia nervosa is a serious and commonly fatal psychological condition. It is essential that nurses develop positive relationships with patients to enable successful treatment. However, these relationships are often difficult to form. This article discusses how the features of

anorexia affect creating and sustaining effective nurse-patient relationships.

Developing trusting relationships with patients is fundamental to nursing practice – particularly in mental healthcare. However, this can be hard to achieve with some patients, such as those with anorexia nervosa (AN), a rare but serious psychological disorder.

The National Institute for Health and Clinical Excellence (NICE, 2004) acknowledges that treating patients with AN can be challenging, particularly because many are ambivalent about treatment.

Although only 0.3-0.7% of the population experience AN, it has a major impact (Kaye et al, 2000) on the physical and

psychological wellbeing of those who do, and on carers, who may blame themselves for contributing to it (Whitney et al, 2005).

As well as the primary effects of AN, patients may also experience secondary effects such as a negative impact on social relationships, education, work, leisure and daily living skills (NICE, 2004). The disorder can be expensive to treat, often requiring hospitalisation (Crow and Nyman, 2004).

Anorexia nervosa

The American Psychiatric Association (2000) says AN is characterised by a refusal to maintain an appropriate body weight, achieved by severe caloric restriction.

People are considered to have the condition if their weight is less than 85% of the norm for their height. To achieve this low weight, patients may engage in potentially health damaging behaviours such as vomiting, purging with laxatives, excessive exercise and restricting food intake.

As a result, AN can have serious complications, such as electrolyte imbalances, renal failure, arrhythmias and amenorrhoea (the absence of menstrual bleeding) (NICE, 2004; APA, 2000; Sullivan, 1995). It is one of the most commonly fatal psychological disorders, resulting in death in around 10% of cases (Sullivan, 1995).

Body dissatisfaction

Anorexia almost invariably begins with weight loss through dieting, precipitated by body dissatisfaction (Attia and Walsh, 2009). This can derive from many sources, but is commonly a result of teasing by peers or parents, exposure to thinness ideals, or modelling of parental behaviour (Polivy and Herman, 2002).

Patients can experience extreme dissatisfaction, which may relate to a distorted view of their own and the ideal body size (Kaye et al, 2000). Many meet the diagnostic criteria for body dysmorphic disorder, which is characterised by a distorted and distressing perception of a body part or the entire body (APA, 2000).

Recognising this may help nurses to understand the distress patients with AN experience, and to adopt a sympathetic attitude. Glauert et al (2009) pointed out that less severe body dissatisfaction is extremely common, and nurses can reflect on this when attempting to relate to patients with AN. It is also important that nurses consider the difference between normal body dissatisfaction and the intense pathological dissatisfaction often felt by patients with AN.

5 key points

1 Health damaging behaviours associated with anorexia nervosa can be fatal or lead to serious complications

2 Positive nurse-patient relationships are crucial if treatment is to be effective

3 Many patients are cared for by nurses without specialist knowledge of the condition

4 Nurses should seek to overcome negative attitudes to patients with AN by understanding the complexities of the disorder

5 Nurses should express acceptance, hopefulness and availability to AN patients



Complex: anorexia cannot be solely explained in terms of weight issues

Psychological characteristics

Other psychological characteristics set patients with AN apart from people with non-pathological body dissatisfaction.

Perfectionism, sociotropy (dependency and a need to please) and narcissism all correlate with AN, suggesting patients find the mismatch between their extreme body ideals and their own perceived body intolerable (Cassin and von Ranson, 2005).

Consistent with this idea is the sense that others are demanding perfection (externally derived perfectionism). This perception diminishes with treatment, but the demand for perfection from oneself (internally derived perfectionism) does not (Cassin and von Ranson, 2005).

This indicates that what may differentiate those at risk of AN who develop the disorder from those who do not is whether they internalise the thin ideal.

Glauert et al's (2009) findings support this hypothesis. They showed images of bodies of different sizes to female students aged 16-31, and found some women were far more sensitive to being exposed to images of thin bodies than others and more likely to see them as normal or ideal.

Disease complexity

Nurses who are aware of the distress AN patients may be experiencing have the best chance of developing and maintaining a positive relationship with them.

To understand the complexity of AN, it is important to recognise it cannot be solely explained in terms of body or weight issues. It is often a coping strategy in response to stressors or negative emotions.

Patients often show a restricted range of emotions, difficulty in identifying

these emotions and inadequate problem-solving skills, which make it difficult for them to develop positive relationships with carers. They may also use eating or exercise as a means of managing negative moods (Lobera et al, 2009).

This theory is supported by AN's high comorbidity with substance misuse – an externalising disorder – and mood and anxiety disorders, which are characterised by negative emotion and a lack of positive emotion (Polivy and Herman, 2002).

Factors that generate stress and negative emotion, such as childhood sexual abuse or a dysfunctional family environment, increase vulnerability to AN (Polivy and Herman, 2002).

People who are predisposed to negative emotion, such as those who score highly on a measure of neuroticism (MacLaren and Best, 2009) or suffer from borderline personality disorder (Paris, 2009), are overrepresented in the AN statistics.

Nurse-patient relationships in AN

Engaging in a therapeutic relationship with patients is vital to the success of any psychological therapy (NICE, 2004).

AN patients see a strong therapeutic relationship as central to their care, so those providing care should be understanding and non-judgemental (Van Ommen et al, 2009; Tierney, 2008). This is consistent with the Nursing and Midwifery Council (2008) code, which says "the people in your care must be able to trust you with their health and wellbeing".

A positive nurse-patient relationship can help increase self-esteem in patients with AN, which increases the chance of treatment being successful (Karpowicz et al, 2009; George, 1997). Snell et al (2010) said nurses see themselves as having a key role in negotiating relationships between patients and fellow team members.

Barriers to a positive relationship

The care of patients with AN is complex, and a number of factors can undermine the potential for a positive relationship between nurse and patient.

Patients often lack insight into their disorder, failing to grasp its serious nature. It is common for them to actively resist treatment (Attia and Walsh, 2009; Tan et al, 2007). They are likely to have little flexibility in thinking (Vanderlinden, 2008), which makes it extremely difficult to tackle resistance through persuasion.

In some cases, force-feeding may be necessary to keep patients alive (Thiels, 2008) but this can damage self-worth and trust in carers.

“Using a phone to talk to patients is not as different as you may first think”

Antonina Kimonge p28



Treatment is also complicated in that nurses and patients may have highly discrepant goals – patients may resist treatment and seek different outcomes than those sought by nursing staff (Wright, 2010). Non-concordance and its implications for a positive nurse-patient relationship may be exacerbated by a general mistrust of others, and a reluctance to relinquish control, which is often characteristic of patients with AN (George, 1997).

The power imbalance inherent in the nurse-patient relationship is likely to exacerbate this. Communication is not seen as being on equal terms, which compromises nurses' attempts to form positive alliances with their patients (Wright, 2010).

Non-concordance may be frustrating for nurses, and lead to negative attitudes towards patients. This will make a positive nurse-patient relationship less likely.

Negative attitudes towards AN itself also have implications for nurse-patient relationships. According to Crisafulli et al (2008), how the disorder is conceptualised can affect nurses' attitudes. In a study of 115 student nurses, they found that those presented with a biological or genetic explanation for the disorder were less likely to have blaming attitudes towards AN patients than those given a sociological explanation. Although this was no longer considered significant after adjusting for multiple comparisons, it does suggest an influence on the nurse-patient relationship that could be amenable to change.

These findings imply that nurses should be made aware of biological influences. Although much is still unknown, the disorder appears to be strongly influenced by familial factors, and is inherited in 50-90% of cases. This is likely to be due to a number of genes each making a small contribution to producing a predisposing temperament (Kaye et al, 2000).

One way in which these genes may take effect is by impairing the functioning of serotonin pathways in the brain. This impairment has been implicated in two features of AN: obsessionality and pathological behaviour regulation (Polivy and Herman, 2002).

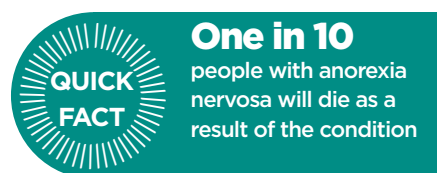
A greater awareness of the complexity of the other influences on AN may also help nurses to empathise with patients.

Since many patients are not treated in specialist AN wards but in general health-care settings, nurses involved in their care may not have had AN training. The research suggests it would be beneficial

for nurses without specialist training to be made aware of some main issues surrounding AN, its causes and treatment.

Discussion

Caring for patients with AN can involve marked deviations from traditional therapeutic relationships, making it more difficult to foster positive nurse-patient relationships. For example, in contrast to most therapeutic relationships, nurses



may find their goals are at odds with patients', and they may have to assert power and authority simply to keep patients alive.

The prognosis in AN is poor, with a recovery rate of only 50% and a mortality rate of around 10% (Kaye et al, 2000). This can add to stressors experienced by nurses.

It is important that these challenges and stressors are acknowledged and addressed through processes such as self-reflection, supervision and multidisciplinary peer support.

Nurses should also seek to overcome negative attitudes to patients with AN by keeping informed about the complexities of the disorder and expressing acceptance, hopefulness and availability (Snell et al, 2010). In achieving this, nurses can feel assured they will be better able to contribute positively to the treatment of patients with this serious disorder. **NT**

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